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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **02 - 03**

2. STATE: **Texas**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **July 1, 2002**

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Social Security Act §1902 (13) (B)

7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT
a. FFY **2002** **$ 3,785** *
b. FFY **2003** **$ 22,644**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
SEE ATTACHMENT

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SEE ATTACHMENT

10. SUBJECT OF AMENDMENT:

Amendment 622 clarifies that the payments for hospice services in an ICF/MR facility are made in accordance with page 31e section 3.8 of the State Plan and that the hospice provider pays the ICF/MR provider 95% of the daily reimbursement rate for room and board.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Sent to Governor's Office this date. Comment, if any will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Linda K. Wertz 06

13. TYPED NAME:
Linda K. Wertz

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
June 20, 2002

16. RETURN TO:
Linda K. Wertz
State Medicaid Director
Post Office Box 13247
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 20, 2002

18. DATE APPROVED: July 9, 2002

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2002

20. SIGNATURE OF REGIONAL OFFICIAL:
for Calvin G Cline

21. TYPED NAME: Calvin G. Cline

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS: * Pen & ink change made per State's request.

FORM HCFA – 179 (07-92)

Attachment to HCFA – 179 for
Transmittal No. 02-03, Amendment No. 622

Number of the Plan Section or Attachment	Number of the Superceded Plan Section or Attachment
Attachment 4.19-D	Attachment 4.19-D
Page 10	Page 10 (TN01-04)
Page 12	Page 12 (TN01-04)

central office overhead expenses, interest income is offset against interest expenses before the allocation of central office costs to individual ICFs/MR.

V. Reimbursement Determination.

TDMHMR reimburses Texas Medicaid ICF/MR providers for services provided to eligible consumers in ICF/MR facilities. HHSC determines reimbursement rates at least annually for two types of facilities: state-operated and non-state operated.

A. **Reimbursement – for State-operated Facilities.**
HHSC determines interim reimbursement annually. Interim Rates are uniform statewide by class and do not vary by level of need. Interim rates are set prospectively with annual settle-up.

1. **Description of rate class**. The state-operated facilities are divided into classes that are determined by the size of the facility.

(a) There is a separate interim rate for each class of state-operated facilities, which are as follows:

(1) Large facility – A facility with a Medicaid certified capacity of 17 or more as of the first day of the full month immediately preceding a rate's effective date or, if certified for the first time, after a rate's effective date, as of the date of the initial certification.

(2) Small facility – A facility with a Medicaid certified capacity of 16 or less as of the first day of the full month immediately preceding a rate's effective date or, if certified for the first time after a rate's effective date, as of the date of initial certification.

2. **Determination of state-operated facility rates**.
Eligible state-operated facilities are reimbursed an interim rate with a settlement except as provided for on page 31e, section 3.8 regarding Hospice services. HHSC will adopt the interim reimbursement rate for state-operated facilities in the following manner:

(a) State-operated facilities will be reimbursed using an interim reimbursement rate and settle-up process.

(1) Interim per diem reimbursement rates for each class of state-operated facilities are based on the most recent cost report accepted by HHSC adjusted to reflect changes in projected expenditures resulting from changes in economic conditions, occupancy levels, and projected operating budgets.

(2) Settlement is conducted annually on a facility by facility basis. If there is a difference between allowable costs and the reimbursement paid under the interim rate, including applied income, for a state fiscal year, federal funds to the state will be adjusted based on that difference.

STATE Texas	A
DATE RECD 06-20-02	
DATE APPVD 07-09-02	
DATE EFF 07-01-02	
HCFA 179 TX-02-03	

SUPERSEDES: TN- TX-01-04

as of the date of initial certification.

2. **Rates effective date.** HHSC rates to be effective January 1st of each calendar year unless otherwise specified by HHSC.

3. **Per Diem Rate**. Non-state operated facility rate include payment for a full 24-hours of ICF/MR services except as provided for in V.B.7 of Attachment 4.19-D (ICF/MR) regarding durable medical equipment, page 17 of Attachment 4.19-B (ICF/MR) regarding dental services and page 31e, section 3.8 regarding hospice services.

4. **Levels of need**. Non-state operated per diem reimbursement rates will be differentiated based on consumer level of need and the facility class. The level of need system is a classification system that differentiates rates based on the needs of the individuals served.

   (a) The level of need classification is based upon The Inventory For Client and Agency Planning (ICAP) service levels. Individuals are classified in the intermittent category if they have an ICAP service level of 7, 8, or 9; individuals are classified at a limited level if they have an ICAP service level of 4,5, or 6; individuals are classified at an extensive level if they have an ICAP service level of 2 or 3; and individuals are classified as pervasive if they have an ICAP service level of 1.

   (b) For individuals who have extraordinary medical needs or behavioral challenges, there is an opportunity to adjust the level of need to more appropriately reflect level of service needed. Individuals who receive 3 or more hours of nursing service a week are eligible to be moved to the next higher level of need category. An individual cannot move to the next higher level of need category for both a medical and behavior reason. For individuals who have dangerous behaviors that require 1:1 supervision at least 16 hours per day, and special category has been developed, pervasive plus. The levels of need are defined as follows:

      (1) intermittent-infrequent personal care and /or regular supervision is required to meet the consumer's needs;

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SUPERSEDES: TN- TX-01-04